FINANCIAL IMPACT OF THE PROSPECTIVE PAYMENT SYSTEM ON MEDICARE PARTICIPATING HOSPITALS - 1984

OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDIT

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

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Memorandum

Date

From Richard P. Kusserow
Inspector General

Subject OIG Report - Financial Impact of the Prospective Payment System on Medicare Participating Hospitals - 1984
ACN: 09-62021

To William L. Roper, M.D.
Administrator
Health Care Financing Administration

In 1983 Congress enacted P.L. 98-21 which included a Medicare Prospective Payment System (PPS), effective October 1, 1983. Under PPS, acute care hospitals are paid according to individual patient diagnoses as categorized into 468 Diagnosis Related Groups. Prospective payment rates for the first 4 years are based on a blend of a hospital specific rate per discharge and a Federal rate. After the 4 year transitional period the payments are to be based on a 100 percent Federal rate. 1/ PPS rates reimburse for inpatient operating costs except for specifically excluded items such as capital, direct medical education and bad debts. PPS created financial incentives to reduce the rate of increase in escalating Medicare expenditures.

Since the inception of PPS, there have been concerns over its financial impact on hospital operations. Some hospitals have complained of financial losses under PPS while others have reported record setting profit margins. The OIG initiated a study to determine the financial impact of PPS on hospitals in 1984. In our study, we analyzed 2,099 Medicare cost reports submitted by hospitals in 18 States. These cost reports represent 39 percent of the 5,405 total hospitals participating in PPS in 1984.

HIGHLIGHTS OF STUDY RESULTS

Our study indicates that the 2,099 hospitals earned Medicare profits of almost $2.2 billion, (Exhibit A), resulting in a net profit margin of about 15 percent on Medicare revenues and in a return on investment (equity) of 25 percent. If the results of the sample are representative, participating hospitals may have earned a net $5.5 billion (Exhibit B) in Medicare profits in their first year of PPS.

1/ Medicare Program; Fiscal Year 1986 Changes to the Inpatient Hospital Prospective Payment System; Interim Final Rule, Federal Register, Tuesday, May 6, 1986, DHHS, HCFA, 42 CFR Parts 400, 405, 412, and 489.

Other highlights of our study results are that:

- 82 percent of the 2,099 facilities earned profits averaging $1.3 million per facility.
- 18 percent of the sampled hospitals incurred losses averaging $155,000 per facility.
- Average profits were eight times the size of average losses.
- 204 of the hospitals (9.7 percent of those reviewed) realized the largest profits, averaging $5.9 million per facility, with the largest profit being $24 million from $88 million of Medicare revenue.
- 97 percent of teaching institutions made profits compared to 79 percent of non-teaching facilities.
- Teaching hospitals had a 47 percent higher profit margin (18.28 percent) than that of non-teaching facilities (12.42 percent). The teaching hospital margin included the additional Medicare payments for indirect medical education. But, even without these added payments, the teaching hospital margin (15.08 percent) would have been 21 percent larger than the non-teaching margin.
- Investor-owned hospitals had a 21 percent higher profit margin (17.89 percent) than non-profit institutions (14.75 percent). The investor-owned margin was greater because of the Medicare payments for return on equity capital. Without these extra payments, the investor-owned margin would still have been high--13.24 percent.
- 91 percent of urban hospitals profited compared to 71 percent of rural hospitals. The urban profit margin was 16.08 percent while the rural margin was 9.22 percent.
- Facilities with more certified beds tended to have higher profit margins.

These Medicare profits resulted, in part, because established PPS rates were based on overstated hospital inpatient operating costs. Our studies of operating costs used to establish the PPS standardized rates have reported that:

- PPS rates improperly include capital costs for ancillary and special care services that should have been excluded from total operating costs.
- All capital costs not specifically identified on the cost reports were included in the PPS rates.

- Nursing school and paraprofessional medical education costs for ancillary and intensive care services were not properly excluded from total operating costs.

- The costs of exempt hospital units (rehabilitation, psychiatric and alcoholic), now reimbursed separately on a cost basis under PPS, were also included in the base period costs used to develop the Federal rates.

The GAO has also reported in various audit reports that PPS rates are overstated because they were based on unaudited costs which included unallowable amounts as well as costs of unnecessary hospital ancillary services; inappropriate costs for respiratory therapy services; erroneous, obsolete cost data on the use of cardiac pacemakers; and, the higher cost of avoidable intensive care services.

Since the implementation of PPS, HCFA regulations have changed the methods, amounts and factors used to determine PPS rates. The Department, recognizing that the PPS payments were overstated, issued regulations to freeze (implement a zero update factor) the 1986 PPS rates at the 1985 payment levels. This was a positive step. This action, however, did not correct for the deficiencies in the base used to develop the standardized amounts.

We have previously recommended that HCFA rebase the PPS rates using audited cost data to correct for deficiencies in the present data and to reflect recent hospital behavior under PPS incentives. The Office of the General Counsel has indicated, however, that rebasing the PPS rates may not be possible without legislative authority. Therefore, we are now recommending that HCFA:

- Clarify the legal basis to rebase. If a legislative change is required, HCFA should seek Congressional authority to recompute the DRG rates using more accurate, audited cost information.

- Rebase the DRG rates after the full transition has been made to a 100 percent Federal rate. This will allow for the DRG rates to be developed utilizing to the fullest extent hospital behavior under PPS.

BACKGROUND

The Congress enacted a Medicare Prospective Payment System for inpatient hospital services effective for hospital cost reporting periods beginning on or after October 1, 1983. The system was developed as a means of controlling the growth in Medicare expenditures. Medicare inpatient costs escalated

from $4.6 billion in 1970 to $38.5 billion in 1983, more than a eight fold increase. Placing hospitals under a prospective payment system gives hospitals an incentive to control costs because they can profit or lose depending on whether their costs are below or above the prospective payment rates.

Medicare payments based on fixed predetermined rates represent the average nationwide cost of treating a patient for a particular illness. During a 4 year transition, hospital payments are based on a blending of the Federal rate with a rate based on hospitals' historical reasonable costs. By FY 1988,. Medicare's payments are to be based on 100 percent Federal rates for hospitals.

In addition to the payment rate for each allowable discharge, teaching hospitals can receive additional inpatient payments for indirect medical education and proprietary hospitals can receive a payment for return on equity. Also, certain hospital inpatient costs, such as capital, direct medical education and bad debts, are excluded from the prospective payment system and continue to be paid on a reasonable cost basis.

SCOPE OF STUDY

The objective of the study was to determine the financial impact of PPS on hospitals by analyzing the extent of profits and losses made by hospitals in their first year of PPS. The field work was conducted at Medicare fiscal intermediaries in 18 States across the country. The 18 States included: Alaska, California, Colorado, Connecticut, Florida, Georgia, Illinois, Kansas, Michigan, Minnesota, Missouri, North Carolina, Ohio, Oregon, Pennsylvania, Texas, Washington, and Wisconsin.

All complete first year Medicare cost reports that were on hand at the fiscal intermediaries were surveyed. The data used in our study were taken from unaudited cost reports which were certified by hospital representatives as being true, correct and complete.

Two widely recognized measures of profitability were considered in our study. The first was the profit margin on Medicare inpatient revenues: the ratio of Medicare profits to Medicare revenues. We defined Medicare profit as the difference between a hospital's reported Medicare inpatient revenue and Medicare inpatient costs. In determining Medicare inpatient revenue, we included return on equity, DRG revenue, outliers, and indirect medical education (IME) payments. In developing Medicare inpatient operating costs, Medicare pass through amounts such as capital, direct medical education and bad debts were not included since these items are reimbursed independently of the PPS mechanism.

The second measure of profitability we used was return on equity: the ratio of the profit earned by hospitals to net worth (assets minus liabilities). We computed a return on equity for both profit and non-profit hospitals as it related to Medicare inpatient services. This was done by allocating a portion of the equity to Medicare inpatient services on the basis of revenue.

There were 2,494 hospital cost reports on hand at 18 fiscal intermediaries at the time of our visits, representing 46 percent of hospitals participating in PPS. Included in the 2,494 reports were 354 reports that were not complete or contained errors which precluded us from using them in the study. Another 41 reports which covered 6 or less months of PPS results were excluded from the study because of the short PPS period covered. In total 2,099 complete, unaudited cost reports representing 39 percent of all participating hospitals were analyzed.

We made no attempt to determine profit or loss for non-Medicare hospital business or for the hospitals' total business operations.

RESULTS OF STUDY

The cost reports we reviewed indicate that hospitals realized a net average profit of about 15 percent. The hospitals in our study earned a net profit of almost $2.2 billion for their first year under PPS. Based on these results, we estimate that profits for all hospitals under PPS could amount to $5.5 billion. This estimated profit may even be understated because it was based on hospital costs which were not audited. Hospitals have historically overstated allowable costs on cost reports submitted to Medicare. For example, the Medicare fiscal intermediary in Southern California advised us that hospitals there had overstated their allowable costs in the past by about 11 percent. The GAO has reported that the overstatement of costs generally averages about 3 percent. 2/

As part of our profit study, we arrayed the profit data into a number of subgroups including the hospitals' teaching status, geographical location and type of ownership. Each subgrouping will be discussed in the following paragraphs.

2/ Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare's Prospective Payment System Rates (GAO/HRD-85-74, July 18, 1985)

Comparison of Winning and Losing Hospitals

Of the 2,099 hospitals surveyed, 1,712 (82 percent) posted a profit, and 387 (18 percent) a loss. The winning hospitals had profits totaling $2.2 billion, an average of $1.3 million per facility. The losses of the 387 hospitals, on the other hand, were much smaller, totaling $60 million or $155,000 per facility.

There were clear differences between winning and losing hospitals. Profit makers had four times more Medicare revenue (an average of $8 million) than losing facilities (an average of $2 million). The profit makers were also found to be much larger institutions. They averaged 192 certified beds compared to only 83 for losing hospitals.

Almost all teaching facilities (97 percent) profited compared to 79 percent for non-teaching hospitals. Similarly, most investor-owned (87 percent) and non-profit (81 percent) hospitals posted profits. Most of the urban hospitals (91 percent) profited compared to 71 percent for rural facilities.

A comparison of winning and losing hospitals is summarized in Exhibit C.

High Profit Hospitals

The 204 hospitals (9.7 percent) with the highest profits earned $1.2 billion, or 54 percent, of the hospital profits. Their profits averaged $5.9 million per facility, almost nine times the average of the other 1,508 profitable hospitals.

Three of the 204 hospitals accounted for $68 million of profits. All three were tax exempt, teaching facilities.

- o One of the facilities located in Ohio earned $24 million on $88 million of Medicare revenue. Its profit margin and return on equity were 27 percent and 25 percent, respectively.

- o Another teaching hospital in California earned $22 million of profits on $52 million of Medicare business. The profit margin for this hospital was 42 percent, while its return on equity came to 104 percent.

- o The third was a Texas hospital that earned $22 million on $55 million of Medicare revenue. Its profit margin and return on equity were 40 percent and 38 percent, respectively.

The large profits of the 204 facilities helped increase the weighted profit margin of the winning hospitals. However, even without the top 204 hospitals, the weighted profit margin of the other 1,508 winning hospitals would still have been high--12.72 percent.

The profit range of the 1,712 winners is shown in Exhibit D, with profiles of the top 204 winners and the other 1,508 summarized in Exhibits E and F, respectively.

Highest Loss Hospitals

Just as a relatively small number of hospitals accounted for the largest profits, 58 hospitals (2.8 percent) had a disproportionate share of the losses. The top loss hospitals accounted for 54 percent of the total losses. They had an average loss of $562,000, almost seven times the average loss of $84,000 for the other 329 losing facilities.

Two of the 58 facilities had $4.4 million of losses between them. Both were non-profit and non-teaching facilities.

- The first facility located in rural Georgia lost $2.6 million on $6.5 million of Medicare revenue. Its loss margin and loss on equity were 40 percent and 53 percent, respectively.

- The second was an urban hospital in Pennsylvania that lost $1.8 million on $10.7 million of Medicare revenue. The loss margin for this hospital was 17 percent and the loss on equity 32 percent.

The top loss hospitals had more Medicare business and were bigger institutions than the other losing facilities. They averaged $5.1 million in Medicare revenue compared to $1.5 million for the other losing facilities, and had an average of 177 beds compared to 66 for the other 329. The top losers were generally urban facilities (66 percent) in contrast to the others which were only 19 percent urban.

The range of losses for the 387 losers is shown in Exhibit G, with profiles of the top 58 losers and the other 329 summarized in Exhibits H and I, respectively.

Teaching and Non-Teaching

Almost all (97 percent) of the 327 teaching hospitals in the sample earned a profit compared to 79 percent of the 1,772 non-teaching facilities. Not only did more teaching hospitals profit, they earned a considerably higher profit margin and return on equity than non-teaching facilities. The profit margin of teaching facilities was 47 percent higher than that of non-teaching hospitals (18.28 percent vs. 12.42 percent). Similarly, the return on equity of teaching hospitals was 32 percent higher than that of non-teaching hospitals (28.60 percent vs. 21.65 percent).

One reason the teaching profit margin was so much higher was that it included $240 million of additional Medicare payments given to the 327 hospitals for indirect medical education.

If Medicare had made no IME payments, the profit margin for the 327 teaching hospitals would still have been 21 percent higher than that of non-teaching hospitals (15.08 percent vs. 12.42 percent) and the return on equity would have been 8 percent higher (23.34 percent vs. 21.65 percent). These large profits raise questions whether the additional IME payments to teaching hospitals were necessary during the first year of PPS.

A separate OIG audit, issued on May 15, 1986, recommends reductions in the IME payments to teaching hospitals. 3/

A comparison of teaching and non-teaching hospitals is shown in Exhibit J, with profiles of the winning teaching and non-teaching facilities summarized in Exhibits K and L, respectively.

Investor-Owned and Non-Profit

We reviewed 214 investor-owned and 1,885 non-profit hospitals. Eighty-seven percent of the investor-owned earned profits compared to 81 percent for the non-profit.

The investor-owned hospitals had a net average profit of $881,000, which was less than the average of $1.1 million for non-profits. But, the investor-owned profit margin (17.89 percent) was 21 percent higher than that of non-profit institutions (14.75 percent). And their return on equity of 44.71 percent was 87 percent higher than that of non-profits (23.87 percent).

A major factor for the investor-owned margin being higher than that of non-profits was the added Medicare payments of return on equity capital. The 214 facilities in the sample received $56.5 million of such payments. If return on equity payments were eliminated, the investor-owned hospitals would have had a 13.24 percent profit margin.

In our previous study dated July 9, 1984, we recommended the elimination of return on equity capital since proprietary hospitals could earn higher profits under PPS than non-profit

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3/ Medicare Indirect Medical Education Payments to Teaching Hospitals (DHHS-OIG-OA, ACN: 09-62003)

hospitals. 4/ This study showed for proprietary hospitals an average operating cost lower than the average of all hospitals. We also recommended in testimony before Congress that return of equity capital be excluded from any policy to incorporate capital under the prospective payment system. 5/ Subsequently the Congress enacted legislation to phase-out return on equity payments over a 3 year period starting October 1, 1986. 6/

A comparison of investor-owned and non-profit hospitals is shown in Exhibit M, with profiles of winning investor-owned and non-profit facilities summarized in Exhibits N and O, respectively.

Urban and Rural

Urban hospitals earned far greater profits than rural facilities, though most rurals did earn a profit. About 91 percent of the 1,099 urbans in the sample profited compared to 71 percent of the 1,000 rurals. The difference in net profits between urbans and rurals was great.

- o The average profit was $1.8 million for urbans, $217,000 for rurals.
- o The profit margin was 16.08 percent for urbans, 9.22 percent for rurals.
- o The return on equity was 26.90 percent for urbans, 14.76 percent for rurals.

A comparison of urban and rural hospitals is shown in Exhibit P, with profiles of winning urban and rural facilities summarized in Exhibits Q and R, respectively.

4/ Areas for Consideration in Developing Recommendations for Reimbursing Hospital Capital Costs under the Medicare Prospective Payment System (Priority Audit Memorandum issued on July 9, 1984; ACN: 07-42019.)

5/ Statement by Richard P. Kusserow, Inspector General, Department of Health and Human Services before the Subcommittee on Health, Committee on Ways and Means, House of Representatives on the Payment of Return on Equity Capital to Proprietary Providers by the Medicare Program, May 14, 1985.

6/ Consolidated Omnibus Budget Reconciliation Act of 1985, formerly H.R. 3128.

Number of Beds

We noted that a direct correlation exists between the profit a hospital made under PPS and its number of certified beds. As previously noted, a winning hospital on average had more than twice as many beds (192) as a losing facility (83), and the more beds a hospital had the greater its profit margin. This correlation is illustrated in the schedule below.

Number of Certified Beds	Net Weighted Profit Margin
400 +	17.47%
250 - 399	14.82%
100 - 249	12.91%
50 - 99	11.38%
Under 50	7.39%

Causes of Profits

We believe these Medicare profits occurred, in part, because the PPS Federal rate was based on overstated hospital inpatient operating costs. Although we did not examine hospital rates as part of our profit analysis, our prior audits reviewed the hospital cost data used to develop the prospective payment rates. These audits, summarized below, determined that the 1981 hospital inpatient operating costs used to establish the PPS rates were overstated. Our audits reported that:

- HCFA procedures for excluding capital costs from hospitals' total operating costs were not adequate to exclude all capital costs attributable to and comingled with other costs of ancillary and special care services. For FY 1986, Medicare will pay an additional $400 million for these capital costs in the Federal rates.

- The intermediary audits of hospitals' 1982 or 1983 Medicare cost reports, used to set the hospital specific portion of the 1984 DRG rates, identified about $966 million of "new" capital expenses which had not been identified as capital costs and excluded from the cost base used to develop the Federal PPS rate. The FY 1986 overstatement is estimated at $320 million.

- HCFA procedures for excluding medical education costs in developing the Federal PPS rates did not properly exclude nursing school costs for ancillary services and intensive care as well as costs for paraprofessional medical education. FY 1986 additional Medicare payments for these items will amount to about $70 million.

- o The costs of exempt hospital units (rehabilitation, psychiatric and alcoholic) which are now reimbursed separately on a cost basis under PPS were also included in the base period costs used to develop the Federal rates.

The General Accounting Office has also performed studies which concluded the data used to set prospective payment rates included the cost of unnecessary services and/or inappropriate costs elements. The GAO reports noted the PPS rates include:

- o the costs of unnecessary hospital ancillary services;
- o unallowable costs and inappropriate costs for respiratory therapy services;
- o erroneous and obsolete cost data on the use of cardiac pacemakers;
- o capital costs that also were reimbursed separately; and
- o the higher cost of avoidable intensive care services.

Conclusions and Recommendations

All of the issues above indicate that the base cost data used to set the PPS rates was inflated resulting in increased DRG payments. These overpayments have contributed to the large profits disclosed from our current study. Since the implementation of PPS, HCFA regulations have changed the methods, amounts and factors used to determine PPS rates. The Department, recognizing that the PPS payments, were overstated, issued regulations to freeze (implement a zero update factor) the PPS rates at the 1985 payment levels. Although this was a positive step, this action did not correct for the deficiencies in the base used to develop the standardized amounts.

We have previously recommended that HCFA rebase the PPS rates using audited cost data to correct for deficiencies in the present data and to reflect recent hospital behavior under PPS incentives. The Office of the General Counsel has indicated, however, that rebasing the PPS rates may not be possible without legislative authority.

We, therefore, now recommend that HCFA:

- o Clarify the legal basis to rebase. If a legislative change is required, HCFA should seek Congressional authority to recompute the DRG rates using more accurate, audited cost information.
- o Rebase the DRG rates after the full transition has been made to a 100 percent Federal rate. This will allow for the DRG rates to be developed utilizing to the fullest extent hospital behavior under the PPS.

We will continue to look at the financial impact PPS has had on hospital operations. Our reviews will include further analysis utilizing data accumulated on hospital profits and data presently being accumulated through our longitudinal data base of 240 sample hospitals. We will concentrate on those hospitals which meet the criteria of serving a disproportionate share of low income patients as well as teaching and rural hospitals.

If you or your staff wish to discuss these matters further, please let me know or contact Felix J. Majka, Assistant Inspector General for Audit. We would appreciate a status report, within 60 days, of any action taken or planned on our recommendations. Copies of this report are being provided to other Departmental officials.

Attachments

EXHIBIT A

OVERALL RESULTS BY STATE

State	Number of Hospitals Analyzed	Net Profits Total	Net Profits Average Per Hospital	Weighted Profit Margin	Weighted Return on Equity
Alaska	5	$ 196,838	$ 39,368	1.65%	1.97%
California	214	316,382,169	1,478,421	15.61	27.79
Colorado	66	58,005,815	878,876	16.72	26.62
[illegible]ecticut	27	57,216,092	2,119,115	14.94	22.10
Florida	128	165,279,056	1,291,243	11.80	24.17
Georgia	117	45,278,088	386,992	10.10	15.69
Illinois	125	130,277,502	1,042,220	12.82	19.86
Kansas	119	31,973,255	268,683	11.42	16.74
Michigan	159	173,572,076	1,091,648	13.26	23.32
Minnesota	131	53,032,854	404,831	13.65	24.55
Missouri	119	185,017,633	1,554,770	20.27	31.88
North Carolina	111	96,859,601	872,609	14.81	20.05
Ohio	162	242,928,878	1,499,561	14.47	22.67
Oregon	34	43,129,990	1,268,529	18.64	30.95
Pennsylvania	110	233,861,357	2,126,012	17.76	32.10
Texas	268	202,950,649	757,279	17.92	26.13
Washington	83	54,145,205	652,352	13.69	21.88
Wisconsin	121	93,030,688	768,849	14.43	26.88
Total	2,099	$2,183,137,746			
			$1,040,085	14.97%	24.87%

NOTE: Above data, as well as data on all other exhibits in this report, were obtained from unaudited cost reports submitted by hospitals.

EXHIBIT B

PROJECTION OF PPS PROFITS

Number of Hospitals Analyzed	2,099
Net Profits of Hospitals Analyzed	$2,183,137,746
(Including Return on Equity Capital Payments of $56,534,605)	
Average Net Hospital Profit	$1,040,085
Number of PPS Hospitals at 9/30/84	5,405
Less: Estimated Hospitals with Short Reporting Periods	[89]
Adjusted Number of PPS Hospitals	5,316
	(Note 1)
Total Projected Net Profits ($1,040,085 x 5,316)	$5.529 billion
	(Note 2)
(Including Estimated Return on Equity Capital Payments of $143 million)	

Note 1. The 2,494 cost reports available for our review included 41 (1.64 percent) that had short periods of PPS results and were excluded from the analysis. We have reduced the universe of 5,405 PPS hospitals by 1.64 percent to reflect the estimated number of hospitals (89) with short periods of PPS results.

Note 2. By excluding profits earned by the estimated 89 short period hospitals (see Note 1), our estimate of the net profit of $5.529 billion earned by hospitals in their first year of PPS is most likely understated. Also, the $5.529 billion projection is based on unaudited hospital reported costs which if overstated, as has been the case in the past, would result in the $5.529 billion profit projection being understated.

EXHIBIT C

WINNERS VS. LOSERS

	Winning Hospitals	Losing Hospitals
Number	1,712	387
Percent	82%	18%
Total Profits/<Losses>	$2,243,284,412	<$60,146,666>
Average Profit/<Loss>	$1,310,330	<$155,418>
Weighted Profit/<Loss>Margin	16.26%	<7.73%>
Average Medicare Revenue	$8,061,000	$2,011,246
Average Number of Certified Beds	192	83
Number of Teaching	317	10
Percent	97%	3%
Number of Non-Teaching	1,395	377
Percent	79%	21%
Number of Investor-Owned	187	27
Percent	87%	13%
Number of Non-Profit	1,525	360
Percent	81%	19%
Number of Urban	997	102
Percent	91%	9%
Number of Rural	715	285
Percent	71%	29%

EXHIBIT D

DISTRIBUTION OF PROFITS

Range of Profits	Number of Hospitals	Total Profits	Average Profit Per Hospital	Weighted Profit Margin
$1 to $499,999	837	$ 155,532,852	$ 185,822	8.36%
$500,000 to $999,999	282	201,648,414	715,065	11.40
$1.0 mil to $1.499 mil	164	197,275,546	1,202,900	13.21
$1.5 mil to $1.999 mil	102	179,250,638	1,757,359	14.61
$2.0 mil to $2.999 mil	123	304,162,798	2,472,868	16.81
Subtotal ($1 to $2.999 mil)	1,508	$1,037,870,248		
			$ 688,243	12.72%
$3.0 mil to $3.999 mil	69	$ 238,020,503	$ 3,449,573	18.33%
$4.0 mil to $5.999 mil	71	346,562,765	$ 4,881,166	18.71
$6.0 mil to $9.999 mil	45	334,685,217	7,437,449	22.37
$10.0 mil to $14.999 mil	10	113,028,890	11,302,889	29.04
$15.0 mil to $19.999 mil	6	104,561,136	17,426,856	25.58
$20.0 mil to $24.999 mil	3	68,555,653	22,851,884	35.10
Subtotal ($3.0 mil to $24.999 mil)	204	$1,205,414,164		
			$ 5,908,893	21.37%
Grand Total	1,712	$2,243,284,412		
			$ 1,310,330	16.26%

EXHIBIT E

PROFILE OF TOP 204 WINNERS

Number of Hospitals Earning Over $3.0 million	204
Total Profits	$1,205,414,164
Range of Profits	$3,001,554 to $24,290,718
Average Hospital Profit	$5,908,893
Weighted Profit Margin	21.37%
Weighted Return on Equity	32.70%
Average Medicare Revenue	$27,649,484
Average Number of Certified Beds	511

	Number	Percent
Teaching Status		
Teaching	135	66%
Non-Teaching	69	34
Total	204	100%
Tax Status		
Investor-Owned	11	5%
Non-Profit	193	95
Total	204	100%
Urban vs. Rural		
Urban	201	99%
Rural	3	1
Total	204	100%
Beds		
400 +	136	67%
250 to 399	54	27
100 to 249	13	6
99 or Under	1	-
Total	204	100%

EXHIBIT F

PROFILE OF OTHER 1,508 WINNERS

Number of Hospitals Earning Less Than $3.0 Million	1,508
Total Profits	$1,037,870,248
Range of Profits	$9 to $2,985,578
Average Hospital Profit	$688,243
Weighted Profit Margin	12.72%
Weighted Return on Equity	22.48%
Average Medicare Revenue	$5,411,099
Average Number of Certified Beds	149

	Number	Percent
Teaching Status		
Teaching	182	12%
Non-Teaching	1,326	88
Total	1,508	100%
Tax Status		
Investor-Owned	176	12%
Non-Profit	1,332	88
Total	1,508	100%
Urban vs. Rural		
Urban	796	53%
Rural	712	47
Total	1,508	100%
Beds		
400 +	86	6%
250 to 399	185	12
100 to 249	495	33
50 to 99	391	26
Under 50	351	23
Total	1,508	100%

EXHIBIT G

DISTRIBUTION OF LOSSES

Range of Losses	Number of Hospitals	Total Losses	Average Loss Per Hospital	Weighted Loss Margin
$1 to $49,999	134	$3,154,141	$23,538	1.98%
$50,000 to $99,999	77	ɔ,612,086	72,884	4.55
$100,000 to $149,999	57	7,049,754	123,680	9.66
$150,000 to $199,999	40	7,021,304	175,533	8.94
$200,000 to $249,999	21	4,716,061	224,574	9.57
Subtotal ($1 to 249,999)	329	$27,553,346	$83,749	5.70%
$250,000 to $349,999	18	$5,398,708	$299,928	9.81%
$350,000 to $499,999	15	6,127,459	408,497	10.60
$500,000 to $749,999	15	9,107,137	607,142	10.65
$750,000 to $1.499 mil	8	7,590,247	948,781	9.53
$1.5 mil to $2.599 mil	2	4,369,769	2,184,885	25.54
Subtotal ($250,000 to $2.599 mil)	58	$32,593,320	$561,954	11.04%
Grand Total	387	$60,146,666	$155,418	7.73%

EXHIBIT H

PROFILE OF TOP 58 LOSERS

Number of Hospitals Losing Over $250,000	58
Total Losses	$32,593,320
Range of Losses	$257,945 to $2,589,399
Average Hospital Loss	$561,954
Weighted Loss Margin	11.04%
Weighted Loss on Equity	18.97%
Average Medicare Revenue	$5,088,665
Average Number of Certified Beds	177

	Number	Percent
Teaching Status		
Teaching	6	10%
Non-Teaching	52	90
Total	58	100%
Tax Status		
Investor-Owned	2	3%
Non-Profit	56	97
Total	58	100%
Urban vs. Rural		
Urban	38	66%
Rural	20	34
Total	58	100%
Beds		
400 +	6	10%
250 to 399	8	14
100 to 249	22	38
50 to 99	16	28
Under 50	6	10
Total	58	100%

EXHIBIT I

PROFILE OF OTHER 329 LOSERS

Number of Hospitals Losing Less Than $250,000	329
Total Losses	$27,553,346
Range of Losses	$587 to $247,053
Average Hospital Loss	$83,749
Weighted Loss Margin	5.70%
Weighted Loss on Equity	9.06%
Average Medicare Revenue	$1,468,722
Average Number of Certified Beds	66

	Number	Percent
Teaching Status		
Teaching	4	1%
Non-Teaching	325	99
Total	329	100%
Tax Status		
Investor-Owned	25	8%
Non-Profit	304	92
Total	329	100%
Urban vs. Rural		
Urban	64	19%
Rural	265	81
Total	329	100%
Beds		
400+	1	-
250 to 399	8	2%
100 to 249	51	16
50 to 99	78	24
Under 50	191	58
Total	329	100%

EXHIBIT J

TEACHING VS. NON-TEACHING

	Teaching		Non-Teaching	
	Number	Percent	Number	Percent
Winning Facilities	317	97%	1,395	79%
Losing Facilities	10	3	377	21
Total	327	100%	1,772	100%

	Teaching		
	Before IME Payments	After IME Payments	Non-Teaching
Total Net Profits	$922,727,474	$1,162,784,809 (Note 1)	$1,020,352,937
Average Net Hospital Profit	$2,821,797	$3,555,917	$575,820
Net Weighted Profit Margin	15.08%	18.28%	12.42%
Net Weighted Return on Equity	23.34%	28.60%	21.65%

Note 1. The 327 teaching hospitals received an extra $240,057,335 of Medicare payments for indirect medical education.

EXHIBIT K

PROFILE OF WINNING TEACHING HOSPITALS

Description	Hospitals Number	Hospitals Percent	Total Profits	Average Profit Per Hospital	Weighted Profit Margin
Tax Status					
Investor-Owned	2	1%	$ 3,946,519	$1,973,260	24.40%
Non-Profit	315	99	1,163,285,727	3,692,971	18.58
Total	317	100%	$1,167,232,246		
				$3,682,121	18.59%
Urban vs. Rural					
Urban	303	96%	$1,134,834,675	$3,745,329	18.57%
Rural	14	4	32,397,571	2,314,112	19.45
Total	317	100%	$1,167,232,246		
				$3,682,121	18.59%
Beds					
400+	159	50%	$ 856,639,977	$5,387,673	18.94%
250 to 399	86	27	224,045,472	2,605,180	17.74
100 to 249	59	19	79,029,049	1,339,475	18.20
50 to 99	11	3	7,390,112	671,828	13.23
Under 50	2	1	127,636	63,818	14.65
Total	317	100%	$1,167,232,246		
				$3,682,121	18.59%

Average Number of Certified Beds	424
Average Medicare Revenue	$19,804,010

EXHIBIT L

PROFILE OF WINNING NON-TEACHING HOSPITALS

Description	Hospitals Number	Hospitals Percent	Total Profits	Average Profit Per Hospital	Weighted Profit Margin
Tax Status					
Investor-Owned	185	13%	$187,243,767	$1,012,128	18.49%
Non-Profit	1,210	87	888,808,399	734,552	13.65
Total	1,395	100%	$1,076,052,166		
				$771,364	14.30%
Urban vs. Rural					
Urban	694	50%	$858,921,898	$1,237,640	15.04%
Rural	701	50	217,130,268	309,744	11.99
Total	1,395	100%	$1,076,052,166		
				$771,364	14.30%
Beds					
400+	63	5%	$203,401,840	$3,228,601	14.44%
250 to 399	153	11	296,753,295	1,939,564	14.33
100 to 249	449	32	394,323,585	878,226	14.10
50 to 99	381	27	134,208,261	352,253	14.57
Under 50	349	25	47,365,185	135,717	14.60
Total	1,395	100%	$1,076,052,166		
				$771,364	14.30%

Average Number of Certified Beds	139
Average Medicare Revenue	$5,392,517

EXHIBIT M

INVESTOR-OWNED VS. NON-PROFIT

	Investor-Owned		Non-Profit	
	Number	Percent	Number	Percent
Winning Facilities	187	87%	1,525	81%
Losing Facilities	27	13	360	19
Total	214	100%	1,885	100%

	Investor-Owned		
	Before ROE Payments	After ROE Payments	Non-Profit
Total Net Profits	$131,935,379	$188,469,984 (Note 1)	$1,994,667,762
Average Net Hospital Profit	$616,520	$880,701	$1,058,179
Net Weighted Profit Margin	13.24%	17.89%	14.75%
Net Weighted Return on Equity	33.03%	44.71%	23.87%

Note 1. The 214 investor-owned hospitals received an extra $56,534,605 of return on equity capital payments which were not given to non-profit institutions.

EXHIBIT N

PROFILE OF WINNING INVESTOR-OWNED HOSPITALS

Description	Hospitals Number	Hospitals Percent	Total Profits	Average Profit Per Hospital	Weighted Profit Margin
Teaching Status					
Teaching	2	1%	$ 3,946,519	$1,973,260	24.40%
Non-Teaching	185	99	187,243,767	1,012,128	18.49
Total	187	100%	$191,190,286		
				$1,022,408	18.58%
Urban vs. Rural					
Urban	142	76%	$168,050,957	$1,183,457	18.69%
Rural	45	24	23,139,329	514,207	17.87
Total	187	100%	$191,190,286		
				$1,022,408	18.58%
Beds					
400+	4	2%	$ 13,966,959	$3,491,740	13.48%
250 to 399	14	7	33,143,770	2,367,412	16.20
100 to 249	73	39	99,466,211	1,362,551	20.04
50 to 99	59	32	34,461,890	584,100	19.07
Under 50	37	20	10,151,456	274,364	23.34
Total	187	100%	$191,190,286		
				$1,022,408	18.58%

Average Number of Certified Beds	127
Average Medicare Revenue	$5,501,667

EXHIBIT O

PROFILE OF WINNING NON-PROFIT HOSPITALS

Description	Hospitals Number	Hospitals Percent	Total Profits	Average Profit Per Hospital	Weighted Profit Margin
Teaching Status					
Teaching	315	21%	$1,163,285,727	$3,692,971	18.58%
Non-Teaching	1,210	79	888,808,399	734,552	13.65
Total	25	100%	$2,052,094,126		
				$1,345,635	16.07%
Urban vs. Rural					
Urban	855	56%	$1,825,705,616	$2,135,328	16.71%
Rural	670	44	226,388,510	337,893	12.25
Total	1,525	100%	$2,052,094,126		
				$1,345,635	16.07%
Beds					
400+	218	14%	$1,046,074,858	$4,798,509	17.95%
250 to 399	225	15	487,654,997	2,167,356	15.58
100 to 249	435	28	373,886,423	859,509	13.67
50 to 99	333	22	107,136,483	321,731	13.45
Under 50	314	21	37,341,365	118,922	13.25
Total	1,525	100%	$2,052,094,126		
				$1,345,635	16.07%

Average Number of Certified Beds 200

Average Medicare Revenue $8,374,833

EXHIBIT P

URBAN VS. RURAL

	Urban		Rural	
	Number	Percent	Number	Percent
Winning Facilities	997	91%	715	71%
Losing Facilities	102	9	285	29
Total	1,099	100%	1,000	100%

	Urban	Rural
Total Net Profits	$1,966,366,165	$216,771,581
Average Net Hospital Profit	$1,789,232	$216,772
Net Weighted Profit Margin	16.08%	9.22%
Net Weighted Return on Equity	26.90%	14.76%

EXHIBIT C

PROFILE OF WINNING URBAN HOSPITALS

Description	Hospitals Number	Hospitals Percent	Total Profits	Average Profit Per Hospital	Weighted Profit Margin
Teaching Status					
Teaching	303	30%	$1,134,834,675	$3,745,329	18.57%
Non-Teaching	694	70	858,921,898	1,237,640	15.04
Total	997	100%	$1,993,756,573		
				$1,999,756	16.86%
Tax Status					
Investor-Owned	142	14%	$ 168,050,957	$1,183,457	18.69%
Non-Profit	855	86	1,825,705,616	2,135,328	16.71
Total	997	100%	$1,993,756,573		
				$1,999,756	16.86%
Beds					
400+	218	22%	$1,040,811,533	$4,774,365	17.80%
250-399	210	21	486,806,134	2,318,124	16.10
100-249	337	34	369,572,575	1,096,655	15.55
50-99	154	15	79,335,684	515,167	16.78
Under 50	78	8	17,230,647	220,906	16.76
Total	997	100%	$1,993,756,573		
				$1,999,756	16.86%

Average Number of Certified Beds	266
Average Medicare Revenue	$11,858,693

EXHIBIT R

PROFILE OF WINNING RURAL HOSPITALS

Description	Hospitals Number	Hospitals Percent	Total Profits	Average Profit Per Hospital	Weighted Profit Margin
Teaching Status					
Teaching	14	2%	$32,397,571	$2,314,112	19.45%
Non-Teaching	701	98	217,130,268	309,744	11.99
Total	715	100%	$249,527,839		
				$348,990	12.62%
Tax Status					
Investor-Owned	45	6%	$23,139,329	$514,207	17.87%
Non-Profit	670	94	226,388,510	337,893	12.25
Total	715	100%	$249,527,839		
				$348,990	12.62%
Beds					
400+	4	1%	$19,230,284	$4,807,571	22.58%
250 to 399	29	4	33,992,633	1,172,160	10.97
100 to 249	171	24	103,780,059	606,901	12.13
50 to 99	238	33	62,262,689	261,608	12.35
Under 50	273	38	30,262,174	110,850	13.60
Total	715	100%	$249,527,839		
				$348,990	12.62%

Average Number of Certified Beds	89
Average Medicare Revenue	$2,765,476

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